**PROCEEDING BEFORE THE HONORABLE ALLAN L. MCVEY**
**INSURANCE COMMISSIONER OF THE**
**STATE OF WEST VIRGINIA**

**IN RE:**
**DELTA DENTAL OF WEST VIRGINIA, INC.**
**ADMINISTRATIVE PROCEEDING**
**18-MAP-02006**

# AGREED ORDER ADOPTING REPORT OF MARKET CONDUCT EXAMINATION

NOW COMES, The Honorable Allan L. McVey, Insurance Commissioner of the State of West Virginia, and issues this Order which adopts the Report of Market Conduct Examination for the examination of Delta Dental of West Virginia, Inc. (hereinafter DDWV) for the period of January 1, 2014 through March 31, 2018 based upon the following findings, to wit:

## PARTIES

Allan L. McVey is the Insurance Commissioner of the State of West Virginia (hereinafter the "Insurance Commissioner") and is charged with the duty of administering and enforcing, among other duties, the provisions of Chapter 23 and Chapter 33 of the West Virginia Code of 1931, as amended.

DDWV is a West Virginia non-profit corporation incorporated in 1962. DDWV has no employees or shareholders. DDWV is licensed as a dental service corporation in West Virginia and regulated by the West Virginia Offices of the Insurance Commissioner. DDWV sells and administers insured dental service contracts to West Virginia group purchasers and offers plans on and off the Federal Exchange in West Virginia under the Affordable Care Act.

## FINDINGS OF FACT

Examination fieldwork began on June 25, 2018 and concluded on September 25, 2018. The examination was conducted in accordance with W. Va. Code §33-2-9(c) by examiners duly appointed by the Offices of the West Virginia Insurance Commissioner. The Market Conduct Examination was a statuary examination focusing on the applicable areas of Chapters XVI XX and XXa of the NAIC Market Regulation Handbook and the 2018 Review of Compliance with Qualified Health Plan Minimum Standards protocols developed by Centers for Medicare & Medicaid Services/The Center for Consumer Information and Insurance Oversight. Fifty-six (56) standards were slated for review. DDWV was determined to be compliant with all fifty-six (56) standards examined.

On or about November 2, 2018, the examiner filed with the Insurance Commissioner, pursuant to W. Va. Code §33-2-9, a Report of Market Conduct Examination.

Any Finding of Fact that is more properly a Conclusion of Law is hereby adopted as such and incorporated in the next section.

## CONCLUSIONS OF LAW

The Insurance Commissioner has jurisdiction over the subject matter and the parties to this proceeding.

This proceeding is pursuant to and in accordance with W. Va. Code § 33-2-9. DDWV was compliant with all standards reviewed as evidenced by the Examination Report.

The Insurance Commissioner is charged with the responsibility of verifying continued compliance with West Virginia Code and the West Virginia Code of State Rules by DDWV as well as all other provisions of regulation that the company is subjected to by its Certificate of Authority to operate in the State of West Virginia.

## ORDER

Pursuant to W. Va. Code §33-2-9(j)(3)(A), following the review of the Report of Market Conduct Examination, the examination work papers, and the response of DDWV thereto, if any, the Insurance Commissioner and DDWV have agreed to enter into this Agreed Order adopting the Report of Market Conduct Examination.

It is accordingly **ORDERED** as follows:

The Report of Market Conduct Examination of DDWV for the period ending March 31, 2018 is hereby **ADOPTED** and **APPROVED** by the Insurance Commissioner;

It is further **ORDERED** that within thirty (30) days of the next regularly scheduled meeting of its Board of Directors, DDWV shall file with the West Virginia Insurance Commissioner, in accordance with W. Va. Code §33-2-9(j)(4), affidavits executed by each of its directors stating under oath that they have received a copy of the adopted Report of Market Conduct Examination;

It is finally **ORDERED** that all such statutory notices, administrative hearings and appellate rights are herein waived concerning this Report of Market Conduct Examination and Agreed Order. All such rights are preserved by the Parties regarding implementation or further action taken on such Order by the Commissioner against DDWV.

Entered this 28th day of December, 2018.

The Honorable Allan L. McVey
Insurance Commissioner

**REVIEWED AND AGREED TO BY:**

**On behalf of the INSURANCE COMMISSIONER:**

Jeffrey C. Black, Attorney Supervisor
Regulatory compliance and Enforcement

Dated: 12/21/18

**On Behalf of Delta Dental of West Virginia, Inc.**

By: Michael G. Hankinson
Print Name

Its: EVP/Chief Legal Officer & Chief Compliance Officer

Signature:

Date: December 20, 2018

# Report of Market Conduct Examination

As of March 31, 2018

**Delta Dental of West Virginia, Inc.**
**One Delta Drive**
**Mechanicsburg, PA 17055**

**NAIC COMPANY CODE: 12329**
**Examination Number: WV-WV014-13**

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November 02, 2018

The Honorable Allan L. McVey, CPCU, ARM, AAI, AAM, AIS
West Virginia Insurance Commissioner
900 Pennsylvania Avenue
Charleston, West Virginia 25305

Dear Commissioner McVey:

Pursuant to your instructions and in accordance with W.Va. Code § 33-2-9 & 33-24-4, an examination has been made as of June 30, 2017 of the business affairs of

Delta Dental of West Virginia
One Delta Drive
Mechanicsburg, PA 17055

Hereinafter referred to as the "Company" or "Issuer" or "DDWV". The following report of the findings of this examination is herewith respectfully submitted.

## EXECUTIVE SUMMARY

This is the report of the Market Conduct Examination of Delta Dental of West Virginia conducted by the state of West Virginia, under the authorization of W.Va. Code § 33-2-9 and 45 CFR § 156.1010. The period covered by the examination was January 1, 2014 through March 31, 2018.

The purpose of the examination was to determine the Company's compliance with West Virginia Statutes and Rules, the Affordable Care Act (ACA) and associated Qualified Health Plan (QHP) Issuer Participation Standards. The examiners conducted policy reviews and interviews of Company management of their group eligibility and enrollment procedures including plans offered for small businesses under the Federal Small Business Health Options Program (SHOP). Examiners determined enrollment periods and benefits are outlined by the group employer (Contractholder) as stated in the contract. Further, the Company does not assume any of the obligations required of the Contractholder under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Examiners concluded therefore, to exclude their review of all group enrollment. Additionally, because the company is a stand alone dental provider (SADP), the examination only included a review of the following mandates:

- Guaranteed Availability;
- Guaranteed Renewability;

The Federally Facilitated Marketplace may be referenced in the report as the "Marketplace" and/or the "Exchange".

The examination commenced on June 25, 2018 and concluded on September 25, 2018. The majority of the examination was conducted via remote access. The examination primarily focused on the applicable areas of Chapters XVI, XX, and XXa of the NAIC *Market Regulation Handbook* (including recently adopted ACA standards) and the 2018 *Review of Compliance with Qualified Health Plan Minimum Standards* protocols developed by Centers for Medicare & Medicaid Services/The Center for Consumer Information and Insurance Oversight (CMS/CCIIO). Fifty-six (56) standards were slated for review. The Company was determined to be compliant with fifty-six (56) standards.

*Prior* examination findings included:

- The Company's procedures for file retainment was to only retain the last year of the policy file.
- On one (1) complaint the response timeframe did not meet the required fifteen (15) working days.
- The Company's producer licensing files did not reconcile with the WVOIC files regarding terminated producers.
- The Company inaccurately indicated the agency as producer of record and not the appointed agent of the agency.
- The Company could not provide notification letters for fourteen (14) terminated producers.
- The Company could not provide the reason for producer termination on fourteen (14) producers.

- The Company was found for one (1) year under the examination it was not using the rates filed and approved by the WVOIC.

Examiners found no repeat occurrences of the prior exam findings.

Although there were no major areas of concern found during this examination, commented within the report the Company took corrective action on the following standards prior to examination completion:

- **Standard A3:** Fraud reporting - Although the Company procedure referenced reporting fraud to the state, it did not include specific guidance for mandatory reporting any fraud detection to the West Virginia Insurance Commissioner as required by § 33-41-5.
- **Standard A5 (QHP Participation Standard C15a):** Required contract language - During the examination examiners noted that the Company had included the required Exchange specific language in all third-party contracts except producer contracts.
- **Standard A15 (QHP Participation Standard C10b):** Privacy breach - Prior to the examination the Company recorded one (1) privacy breach wherein a premium invoice went to the wrong address. The Exchange was properly notified, the member was notified and the Company implemented corrective action by adding a new step to the premium invoice mailing process.
- **Standard G6** – Online grievance procedures forms - Although no violations were noted, upon review of the Company's online grievance procedures forms, examiners noted the forms directed and referred members to Delta Dental of California, not West Virginia.
- **Standard H2 (QHP Participation Standard C6):** Provider Directory - The examiner observed one (1) provider telephone number only reached a recording to leave a message and provided no additional information. One (1) other provider was listed on the online directory as accepting new patients; however, during the call the examiner was advised the provider was not taking new DDWV patients.

## SCOPE OF EXAMINATION

The basic business areas examined were:

- Company Operations/Management
- Complaint Handling/Grievances/Appeals
- Marketing and Sales
- Policyholder Services
- Enrollment and Rating
- Claims
- QHP Issuer Participation Standards Compliance

Each business area has standards that were measured during the examination process. Although most standards have statutory or regulatory requirements, others are specific to the Company and contractual guidelines.

The focus of the examination was on the methods used by the Company to manage its operations for each of the business areas subject to this examination. Those areas deemed material were tested to determine if the Company is in compliance with West Virginia statutes and rules.

The examination also included review of certain Affordable Care Act Standards identified in the NAIC *Market Regulation Handbook* as well as verification of compliance with the ***Qualified Health Plan (QHP) Minimum Certification Standards*** outlined in 45 CFR Part 156, Subpart C. These as well as the corresponding test methodologies are emphasized throughout the report as bolded. Review of the QHP standards was performed in accordance with CCIIO's 2018 Compliance Review Protocol-Individual Market and Stand Alone Dental Plan (SADP) as indicated in the following table:

| QHP Issuer Participation Compliance Standard | Compliance Standard |
|---|---|
| C1a | D1 |
| C1b | C3 |
| C2a | E1 |
| C2b | B1 |
| C3 | B6 |
| C4 | B4 |
| C6 | H2 |
| C7 | B4 |
| C8 | B5 |
| C9 | E6 |
| C10 | E6 |
| C10b | A15 |
| C10c | E10 |
| C10d | D3 |
| C10e | E2 |
| C11a | A7, E11 |
| C11b | E11 |
| C12 | G8 |
| C15 | A6, H1 |
| C15a | A5 |
| C15b | C1 |
| C16 | A16 |
| D1 | A17 |

Regarding only Exchange business during the review period, policies issued on the Exchange had eligibility determinations facilitated by the Exchange/Marketplace and communicated to the Company via electronic data interchanges (834), as well as transactions for Benefit Enrollment and Maintenance and Health Information Casework System (HICS). The Company does not enroll, disenroll, cancel, terminate or make any changes to any application or policy without receiving an 834 transaction from the Exchange for Exchange business. The Company utilizes the Exchange's established enrollment reconciliation process to communicate policy coverage changes and ensure accuracy.

The examiners may not have discovered every unacceptable or non-compliant activity in which the Company is engaged. The failure to identify or comment on, or criticize specific Company practices does not constitute an acceptance of the practices by the West Virginia Offices of the Insurance Commissioner.

## HISTORY AND PROFILE

Deltal Dental of West Virginia (the "Company") is a West Virginia non-profit corporation incorporated in 1962. The Company has no employees or shareholders. The Company is licensed as a dental service corporation in West Virgina and regulated by the West Virginia Offices of the Insurance Commissioner. The Company sells and administers insured dental service contracts to West Virginia group purchasers and offers plans on and off the Federal Exchange (Exchange, FFM or Marketplace) in West Virginia under the Affordable Care Act.

The Company has a dental administration agreement with Delta Dental Insurance Company (DDIC) to provide sales and administration of ASO dental service contracts for DDIC in West Virginia. The same agreement also has a management agreement with Delta Dental of Pennsylvania (DDP) under which DDP provides claims adjudication and other adminstrative services for the Company's insured contracts and carries out the Company's claim adjudication and other administrative services obligations to DDIC. The Company has a determination letter stating it is a tax-exempt organization described under IRS Section 501(c)(4).

| YEAR | MARKET | PREMIUMS | WV MARKET SHARE |
|---|---|---|---|
| 2017 | Health | $27,011,499 | 2.35% |

## METHODOLOGY

The examination was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and West Virginia's applicable statutes and regulations. The examiners conducted file reviews and interviews of company management. The examination report is a report by test, rather than a report by exception.

Tests designed to measure the level of compliance with all Federal ACA/QHP statutes and regulations, along with West Virginia's statutes, rules and regulations were applied to the files selected for review. All standards tested and related results are described in this report.

In the results tables, a "pass" response indicates compliance and a "fail" response indicates a failure to comply for each individual file reviewed. The results of each test applied to a sample are reported separately. The examiners used the NAIC standards of 7% error rate on claims test (93% compliance rate) and 10% error rate on all other tests (90% compliance rate) to determine whether or not an apparent pattern or practice of being compliant, predominantly compliant, or non-compliant existed for any given test.

Initial sample sizes were based on the total population, utilizing the Acceptance Samples Table (AST) found in the NAIC *Market Regulation Handbook*, Chapter 14-Sampling. In some cases, the total sample size was reviewed. As the examination progressed, it was decided that after review of a specific number of files and finding no errors, the review was terminated as risk of non-compliance was minimal. The actual samples and categories reviewed are reflected in the tables throughout the report.

**Sampling Methodology – Claims:**

The ACA, federal rule sections 45 CFR §§ 147.150, 147.126, 147.130 and 156.110, requires Companies to provide benefit coverage for the ten (10) Essential Health Benefits (EHB), one (1) being pediatric services (dental), without lifetime or annual limits and without imposing cost sharing on preventive care services performed by in-network providers. The ACA also seeks to ensure benefit coverage for individuals participating in approved clinical trials. Included in these rights, are the non-discrimination requirements related to pre-existing health conditions, dependent coverage up to age 26 and limitations or exclusions due to health status.

To test compliance with the ACA requirements, claims were separated and reviewed into the following two (2) categories which included both on and off Exchange:

- Paid
- Closed without payment (CWOP/denied)

**Sampling Methodology – Enrollment Samples:**

The enrollment and rating review involved the review of samples for new business, and cancellations/terminations.

The following samples were reviewed:

- Open and Special Enrollment Period (SEP) enrollment on Exchange (2018 plan year);
- Enrollment off Exchange (2018 plan year)
- Terminations of policies (2017plan year)

The Marketplace determined all eligibility for Exchange member enrollment and Delta Dental did not perform any further eligibility verification. Consequently the Company did not decline any of those applications during the exam period.

## A. COMPANY OPERATIONS/MANAGEMENT

The evaluation of standards in the Company operations/management business area is based on a review of Company responses to information requests, questions, interviews, and presentations made to examiners. The review is designed to provide a view of the Company structure and how it operates, and is not based on sampling techniques. The review is not intended to duplicate the

management review of a financial examination, but to assist the examiners in gaining a better understanding of the examinee. Many troubled companies have become so because management has not been structured to adequately recognize and address problems that can arise. Well-run companies generally have processes that are similar in structure. While these processes vary in detail and effectiveness from company to company, the absence of the processes or the ineffective application of them often result in failure of various standards tested during an examination. The processes usually include:

- A planning function where direction, policy, objectives, and goals are formulated;
- An execution or implementation of the planning function elements;
- A measurement function that considers the results of the planning and execution; and,
- A reaction function that utilizes the results of measurement activities to take corrective action or to modify the process to develop more efficient and effective management of company operations.

**Standard A.1: The regulated entity has an up-to-date, valid internal or external audit program.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 1)

**Test Methodology:**

- Does the Company have an internal and external audit program to detect structural problems before they occur? [W.Va. Code §§ 33-33-1, 3 & 4]

**Examiner Observations:** The Company's internal and external audit programs and procedures were reviewed, as well as any findings on the list of completed audits performed by the Company as of the date of this report. It appears that the Company's programs and procedures are currently adequate for detecting structural problems before they occur. No exceptions were noted.

*Note: As a result of the Company's internal and external audits and this examination, Corrective Action Plans have been initiated and are referred to throughout the report.*

**Examiner Recommendations:** None

**Results:** Compliant

**Standard A.2: The regulated entity has appropriate controls, safeguards and procedures for protecting the integrity of computer information.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 2)

**Test Methodology:**

- Does the Company have central recovery and backup procedures? [W.Va. Code R. § 114-62-3]

**Examiner Observations:** The examiners reviewed the Company's Business Continuity Program, which outlines directions on how to use the plan for overall governance, risk assessment, enterprise recovery strategies, business recovery and disaster recovery for over-all continuity.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard A.3: The regulated entity has antifraud initiatives in place that are reasonably calculated to detect, prosecute and prevent fraudulent insurance acts.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 3)

**Test Methodology:**

- Does the Company have an adequate, up-to-date fraud plan in compliance with statutes, rules and regulations? [no statutory requirement]
- Does the Company antifraud plan include procedures for the mandatory reporting of possible fraudulent insurance acts to the insurance commissioner or applicable state regulatory agency pursuant to applicable state statutes, rules and regulations? [W.Va. Code § 33-41-5]

**Examiner Observations:** The Company has a Fraud Prevention and Detection Plan in place. The plan includes instructions on reporting of possible fraudulent insurance acts to local, state and federal agencies. There were no cases of suspected fraud reported during the examination period. Although the Company procedure referenced reporting fraud to the state, it did not include specific guidance for mandatory reporting any fraud detection to the West Virginia Insurance Commissioner as required by § 33-41-5. The Company took corrective action prior to the completion of this examination and added specific language to their procedure to report fraud to the insurance commissioner.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard A.4: The regulated entity has a valid disaster recovery plan.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 4)

**Test Methodology:**

- Does the Company have a disaster recovery plan that will detail procedures for continuing operations in the event of any type of disaster? [no statutory requirement]

**Examiner Observations:** The examiners reviewed the Company's Business Continuity Program, which outlines directions on how to use the plan for overall governance, risk assessment, enterprise

recovery strategies, business recovery and disaster recovery for over-all continuity in the event of business interruption. No exceptions were noted.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard A.5: Contracts between the regulated entity and entities assuming a business function or acting on behalf of the regulated entity, such as but not limited to managing general agents (MGAs), general agents (GAs), third party administrators (TPAs) and management agreements must comply with applicable licensing requirements, statutes, rules and regulations.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 5 & **2018 QHP Participation Standards C15a**)

**Test Methodology:**

- **QHP Participation Standard C15a:** Do the contracts between the Company and entities assuming a business function or acting on behalf of the regulated entity, such as but not limited to managing general agents (MGAs), general agents (GAs), third party administrators (TPAs) and other management agreements comply with applicable licensing requirements, statutes, rules and regulations as the Company maintains responsibility for compliance? [W.Va. Code § 33-37-2 and **45 CFR § 156.340(a)**]

**Examiner Observations:** The Company has third-party contracts with entities for credit card processing, printing plan brochures, lockbox transactions, translation services and producer licensing. DDWV does not employ MGAs. During the examination examiners noted that the Company had included the required Exchange specific language in all third-party contracts except producer contracts. The Company agreed and took corrective action by adding the required language prior to examination conclusion.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard A.6: The regulated entity is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the regulated entity.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 6 & **2018 QHP Participation Standards C15**)

**Test Methodology:**

- Do the Company contracts with third-party entities specify the responsibilities of the MGA, GA and TPA concerning record keeping and responsibilities of the regulated entity for conducting audits? [W.Va. Code § 33-37-2 and W. Va. Code R. § 114-53]

- **QHP Participation Standard C15:** Does the Company audit the activities of the contracted entities? [W.Va. Code § 33-37-4 and **45 CFR § 156.340(b)**]
- Did the Company properly address instances (if any) of noncompliance of the contacted entities?
- **QHP Participation Standard C15**: Does the vendor provide performance reports to the Issuer to determine instances of noncompliance being documented and addressed?
- **QHP Participation Standard C15**: Does the Company have contracts with downstream entities, which are in compliance with statutes and regulations including specifying the delegated activities and reporting responsibilities, and providing for revocation of the delegated activities and reporting standards or specify other remedies if determined to have not performed satisfactorily? [**45 CFR § 156.340**]

**Examiner Observations:** All third-party contracts were determined to specify the recordkeeping responsibilities and the responsibilities of the Company to conduct regular audits. The Company provided a list of completed audits and the examiners reviewed audit results of third-party entities conducted during the examination period. Company oversight of third-parties included, but was not limited to, the Company providing procedures which outline specific oversight requirements for downstream and delegated entities, including agents and brokers and providing regulatory guidelines as well as reviewing regulatory agency monitoring.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard A.7: Records are adequate, accessible, consistent and orderly and comply with state record retention requirements.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 7 & **2018 QHP Participation Standards C11a)**

**Test Methodology:**

- Does the Company maintain records in compliance with state record retention requirements? [W.Va. Code § 33-2-9, and W.Va. Code R. § 114-15-4]
- **QHP Participation Standard C11a:** Does the Company adhere to QHP Participation Standard records retention requirements of ten (10) years? [W.Va. Code R. § 114-96-3 and **45 CFR §§ 156.705 &156.270(b)**]

**Examiner Observations:** The Company's records retention schedule was reviewed, and it was determined to be compliant with both state and federal retention requirements.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard A.8: The regulated entity is licensed for the lines of business that are being written.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 8)

**Test Methodology:**

- Does the Company have Certificates of Authority for the lines of business written? [W.Va. Code §33-3-1]
-

**Examiner Observations:** The Company is properly licensed as a stand alone dental plan as required.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard A.9: The regulated entity cooperates on a timely basis with examiners performing the examinations.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 9)

**Test Methodology:**

- Did the Company provide records in a timely basis? [W.Va. Code § 33-2-9 and W.Va. Code R. §114-15-4.9a]

**Examiner Observations:** Company's representatives were cooperative and generally responded to examiners inquiries within the required timeframes.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard A.10: The regulated entity has policies and procedures to protect the privacy of nonpublic personal information relating to its customers, former customers and consumers that are not customers.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 12)

**Test Methodology:**

- Do the Company policies, practices and procedures regarding protection and disclosure of nonpublic personal information of customers, former customers and consumers who are not customers comply with applicable state laws regarding privacy? [W.Va. Code R. §§ 114-57-11 and 114-62-5]

**Examiner Observations:** The examiners reviewed the Company's multiple policies, procedures, training materials and training attendance records procedures regarding the protection of nonpublic personal information to protect the privacy of its customers and no exceptions were noted.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard A.11: The regulated entity provides privacy notices to its customers and, if applicable, to its consumers who are not customers regarding treatment of nonpublic personal financial information.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 13)

**Test Methodology:**

- Do the Company privacy notices comply with applicable state laws? [W.Va. Code R. §§ 114-57-2 and 114-57-5]
- Does the Company provide privacy notices timely as required by applicable state laws? [W.Va. Code R. §§ 114-57-4 and 114-57-8]

**Examiner Observations:** The examiners reviewed Company procedures, templates and website regarding privacy notices. The Company provides multiple links to all privacy notices on its website and provides information on how to request a printed notice. The notice describes in detail how health information about the customer may be used and given out, as well how the customer may request the same information. The notice includes contact information for DDWV for additional requests. No exceptions were noted.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard A.12: If the regulated entity discloses information subject to an opt-out right, the regulated entity has policies and procedures in place so that nonpublic personal financial information will not be disclosed when a consumer who is not a customer has opted out, and the regulated entity provides opt-out notices to its customers and other affected consumers.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 14)

**Test Methodology:**

- Does the Company provide consumers the opportunity to opt out before nonpublic personal information is disclosed? [W.Va. Code R. § 114-57-6]
- Does the Company have the capability to keep nonpublic personal financial information from being unlawfully disclosed to nonaffiliated third parties when a consumer has opted out? [W.Va. Code R. § 114-57-9]

**Examiner Observation:** The Company does not allow disclosure to nonaffiliated third parties without an opt out disclosure signed by the member.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard A.13: The regulated entity's collection, use and disclosure of nonpublic personal financial information are in compliance with applicable statutes, rules and regulations.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 15)

**Test Methodology:**

- Does the Company comply with regulations regarding disclosing nonpublic personal financial information of its customers or consumers who are not customers to nonaffiliated third parties for joint marketing purposes? [W.Va. Code R. § 114-57-11]

**Examiner Observations:** The Company's policies do not allow the disclosure of nonpublic personal financial information to nonaffiliated third parties without an opt out notice signed by the consumer.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard A.14: In states promulgating the health information provisions of the NAIC model regulation, or providing equivalent protection through other substantially similar laws under the jurisdiction of the insurance department, the regulated entity has policies and procedures in place so that nonpublic personal health information will not be disclosed, except as permitted by law, unless a customer or a consumer who is not a customer has authorized the disclosure.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 16)

**Test Methodology:**

- Does the Company obtain valid authorizations from customers and consumers who are not customers before disclosing its nonpublic personal health information, except to the extent such disclosures are permitted? [W.Va. Code R. § 114-57-15]

**Examiner Observations:** The Company obtains authorizations as required for disclosure of nonpublic personal health information to non-affiliated third parties. No exceptions were noted.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard A.15: Each Licensee shall implement a written information security program for the protection of nonpublic customer information.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 17 & **2018 QHP Participation Standards C10b)**
**Test Methodology:**

- Does the Company have procedures for the security of information? [W.Va. Code R. § 114-62-1 et seq.]
- Does the Company have procedures in place to protect the entity's database(s) from various hazards, including environmental? [W.Va. Code R. § 114-62-1]
- **QHP Participation Standard C10b:** Does the Company adhere to specific privacy and security requirements when accepting enrollment information? **[45 CFR §§ 155.260 and 156.265(c)]**

**Examiner Observations:** The Company has both procedures in place for the security of information, as well as to protect databases from hazards. The examiners reviewed the procedures and no exceptions were noted. Prior to the examination the Company recorded one (1) privacy breach wherein a premium invoice went to the wrong address. The Exchange was properly notified, the member was notified and the Company implemented corrective action by adding a new step to the premium invoice mailing process.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard A.16: The Issuer complies with laws regarding data integrity and meeting certification standards. (2018 QHP Issuer Participation Standards C16)**

**Test Methodology:**

- **QHP Participation Standard C16:** Does the QHP Issuer have a QA process and/or plan for verifying the data entered in the QHP Certification templates is accurate? **[45 CFR § 155.1000]**
- **QHP Participation Standard C16:** Does the QHP Issuer have a process and/or plan in place for submission of data corrections due to data errors? **[45 CFR § 155.1000]**
- **QHP Participation Standard C16:** Does the QHP Issuer maintain version control by keeping a record of each version of the template and the date each version was submitted for QHP Certification if there were updates or corrections made to the initial template submission? **[45 CFR § 155.1000]**

**Examiner Observations:** The examiner reviewed the Company's policies and procedures related to verifying QHP template data accuracy prior to certification and submitting data corrections for errors identified after certification.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard A.17: The Issuer has and implements a comprehensive compliance plan. (2018 QHP Issuer Participation Standards D1)**

**Test Methodology:**

- **QHP Participation Standard D1:** Does the Issuer's compliance plan document contain the following seven elements of compliance: [No specific code applies.]
  - Written policies, procedures and Standards of Conduct
  - Designated compliance officer and compliance committee
  - Compliance training and education
  - Effective lines of communication
  - Well-publicized disciplinary standards
  - System for routine monitoring and identification of compliance risks
  - Procedures and system for prompt response to compliance issues

**Examiner Observations:** Contents and evidence of implementation of the Issuer's Compliance Program were reviewed for evidence of compliance with all requirements. No exceptions were found.

**Examiner Recommendations:** None

**Results:** Compliant

## B. MARKETING AND SALES

The evaluation of standards in this business area is based on review of Company responses to information requests, questions, interviews, and presentations made to the examiner. This portion of the examination is designed to evaluate the representations made by the Company about its product(s). It is not typically based on sampling techniques but can be. The areas to be considered in this kind of review include all media (radio, television, videotape, etc.), written and verbal advertising and sales materials.

**Standard B.1 All advertising and sales materials are in compliance with applicable statutes, rules and regulations.** (NAIC *Market Regulation Handbook*– Chapter XVI, § C, Standard 1 & **2018 QHP Issuer Participation Standards C2b)**

**Test Methodology:**

- Are advertising materials free from misrepresentations of policy benefits or false, deceptive or misleading statements. [W. Va. Code R. § 114-10-1 et seq.]
- Do all advertising materials disclose the name of the Company, comply with applicable statutes, rules and regulations and cite the source of statistics used? [W. Va. Code R. § 114-10-1 et seq.]
- **QHP Participation Standard C2b:** Does the Issuer offer pediatric dental? **[45 CFR § 156.110(a)(10)]**

**Examiner Observations:** Contents of advertising materials were reviewed for false or misleading statements and disclosure of the name of the Company. Advertising materials are also reviewed by the WVOIC Rates and Forms Division prior to use. DDWV does offer pediatric dental coverage. No exceptions noted.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard B.2 Company internal producer training materials are in compliance with applicable statutes, rules and regulations.** (NAIC *Market Regulation Handbook*– Chapter XVI, § C, Standard 2)

**Test Methodology:**

- Do all producer training materials comply with state statutes, rules and regulations? [W. Va. Code § 33-11-1 et seq.]

**Examiner Observations:** The Company provided training materials for newly appointed producers. Training format is web based via Company portal and phone based lunch and learn powerpoint presentations. Product material covered includes but was not limited to DDWV Enterprise Compliance of privacy, security, fraud & language assistance programs – general dental industry information and continuing education courses for oral health. Examiners reviewed training materials provided to these individuals for misleading statements or inaccurate content and found no errors.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard B.3 Outline of coverage is in compliance with all applicable statutes, rules and regulations.** (NAIC Market *Regulation* Handbook– Chapter 20 § C, Standard 2 & Chapter 20A Summary of Benefit and Coverage, Standard 2)

**Test Methodology:**

- Are outlines of coverages approved by the WVOIC? [W. Va. Code § 33-28-6]
- Are all health policy mandated benefits and benefit limitations completely and accurately described? [W. Va. Code § 33-28-6]
- Does the Company make the Summary of Benefits and Coverage, Uniform Glossary and Evidence of Coverage (EOC) available without cost to consumers, when "shopping," upon application for insurance, or during a plan or policy year? [45 CFR § 147.200]

**Examiner Observations:** Since West Virginia is a plan management and prior approval state, all policy documents including Evidence of Coverage (EOC), Schedule of Benefits, and Summary of Benefits and Coverage (SBC) are reviewed for the above criteria by the WVOIC Rates and Forms Division prior to use. Examiners also verified that the current SBCs and EOCs are provided upon policy renewal and policy effectuation for individual enrollees. The Company has documents available on its website without login to access. For those without internet access, information is made available by trained staff via phone calls, as well as information being available from direct calls to the Marketplace. Contractholders of group plans provide each enrollee electronic access to the SBC and EOC supplied by the Company and upon request, the Company will also furnish a hard copy to both the enrollee or the contractholder to distribute. These are also reviewed for the above criteria by our Rates and Forms Division prior to use.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard B.4 QHP Issuer must not employ discriminatory marketing practices. (2018 QHP Issuer Participation Standards C4 and C7)**

**Test Methodology:**

- **QHP Participation Standard C4:** Does the Issuer's website contain any discriminatory language or statements? **[45 CFR § 156.225(b)]**
- **QHP Participation Standard C4:** Do any plan documents contain any discriminatory language or statements to discourage enrollment? **[45 CFR § 156.225]**
- Does the Company have prescription drug benefit plans that discourage consumers with high cost prescription drug needs from enrolling? [45 CFR § 156.122(c)]
- **QHP Participation Standard C7:** Does the Issuer make all applications and notices accessible to individuals living with disabilities and individuals with limited English proficiency, to include TTY/TTD at no cost to the individual and advise how to obtain? **[45 CFR § 156.250]**
- **QHP Participation Standard C7:** Do Issuer documents include taglines in non-English languages indicating the availability of lanuage services in at least the top 15 languages spoken by the Limited English Proficient (LEP) population in the state and advise how to obtain? **[45 CFR § 156.250]**

**Examiner Observations:** As previously stated, West Virginia is a plan management state; therefore, plan documents for the above criteria were reviewed during the form review process by the WVOIC Rates and Forms division for critical plan documents. Furthermore, the

Commissioner requires filing of all advertising materials for health plans. Examiners separately reviewed the website as well as plan documents for any discriminatory language or statements to discourage enrollment. No evidence of any discriminatory practices were found during review.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard B.5 QHP Issuer must adhere to rate variation requirements. (2018 QHP Issuer Participation Standards C8)**

**Test Methodology:**

- Does the Issuer charge the same premium rates without regard to whether the plan is offered inside or outside of the Exchange? [**45 CFR § 156.255(b)**]

**Examiner Observations:** Rates were reviewed by the WVOIC Rates and Forms division and the filed rates same for both on and off the Exchange for ACA compliant plans.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard B.6 Transparency in Coverage (2018 QHP Issuer Participation Standards C3)**

**Test Methodology:**

- **QHP Participation Standard C3:** Does the Issuer provide certain information related to transparency in coverage? As stated in **45 CFR § 156.220(a-c),** the QHP Issuer is required to report (in plain language) specific information related to transparency of coverage to the Exchange, Department of Health and Human Services (HHS) and the State Insurance Commissioner, as well as make the information available to the public. In addition, per **45 CFR § 156.220(d),** the QHP Issuer must make available the amount of enrollee cost sharing under the individual's plan or coverage. Such information must be available for individuals without access to the Internet.

**Examiner Observations:** The Company communicates cost-sharing information to members and potential members via mail, over the phone and on its website. Brochures, Summaries of Benefits of Coverage, and Transparency report submitted to CMS were reviewed for transparency of coverage. No issues found.

**Examiner Recommendations:** None

**Results:** Compliant

## C. PRODUCER LICENSING

The evaluation of standards for this business area is based on the review of the CMS database, the West Virginia Offices of the Insurance Commissioner (WVOIC) records, and the Company responses to information requests, questions, interviews, and presentations made to the examiners. The producer licensing review is designed to test the Company's compliance with federal and state producer licensing laws and rules. All training and registration status of all producers selling QHP plans was verified to determine compliance with federal statutes/rules related to the QHP Participation Standards.

**Standard C.1: The producers are properly licensed, appointed, and have appropriate continuing education (if required by state law) in the jurisdiction where the application was taken.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §D, Standard 2 & **2018 QHP Issuer Participation Standards C15b)**

**Test Methodology:**

- Are Company producer appointments effective within fifteen (15) days of the producer writing business on behalf of the regulated entity? [W.Va. Code § 33-12-18]
- Are the producers authorized for the types of business he/she is eligible to solicit? [45 CFR § 156.340]
- **QHP Participation Standard C15b:** Have the producers met the required continuing education and producer training requirements for selling QHP insurance? **[45 CFR § 156.340]**

**Examiner Observations:** The Company represented that it had 122 licensed producers, which matched WVOIC records. For QHP compliance, it is the Company's policy to require these individuals to complete training required by 45 CFR § 156.340. The Company ensures this by completing a validation process through accessing the CMS portal and the WVOIC website. Producers who cannot be validated and do not respond to Company contact for licensing and training are not paid commission.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard C.2: Records of terminated producers adequately document reasons for terminations.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §D, Standard 5)

**Test Methodology:**

- Does the Company properly document reasons for producer terminations? [W.Va. Code § 33-12-25]

- Does the Company properly report to the insurance department producer terminations for cause? [W.Va. Code § 33-12-25]

**Examiner Observations:** Although DDWV properly documented terminated producers during the examination period, no terminations were for cause.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard C.3 The Issuer complies with laws regarding broker compensation. (2018 QHP Issuer Participation Standards C1b)**

**Test Methodology:**

- **QHP Participation Standard C1b:** Is the Issuer's compensation schedule consistent for QHP's offered on and off the Marketplace? **[45 CFR § 156.200(f)]**

**Examiner Observations:** Examiner's reviewed the Company's commission schedules for the examination period and compensation is paid consistently for QHP's offered on and off the Marketplace.

**Examiner Recommendations:** None

**Results:** Compliant

## D. POLICYHOLDER SERVICE

The evaluation of standards related to the Company's business area of policyholder service is based on responses to information requests, questions, interviews, and presentations made to the examiner, and file sampling performed during the examination process. The policyholder service portion of the examination is designed to test the Company's compliance with statutes regarding billing notices, reinstatements, delays, premium refunds, and coverage questions.

**Standard D.1: Reinstatement is applied consistently and in accordance with policy provisions.** (2017 NAIC *Market Regulation Handbook*, Chapter 20, §E, Standard 1 & **2018 QHP Issuer Participation Standards C1a)**

**Test Methodology:**

- Does the Company consistently and in a nondiscriminatory manner comply with the reinstatement provisions of the policy? [W.Va. Code § 33-15-4].

- **QHP Participation Standard C1a: 45 CFR § 156.200(e)** the QHP Issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

**Examiner Observations:** All reinstatement transactions are governed by the Marketplace. Although a separate sample of reinstatements was not reviewed, reinstatements would be contained throughout HICS cases. Review of HICS cases determined that the Company processed reinstatements as instructed by the Marketplace.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard D.2: Policy issuance and insured requested cancellations are timely.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §E, Standard 2)

**Test Methodology:**

- Does the Company handle insured requested cancellations in a timely manner without excessive paperwork requirements for the insured? [W.Va. Code § 33-11-1 et seq.]

**Examiner Observations:**

The Company had no individual off Exchange policy cancellations for the review period.

The review under this standard consisted of individual Exchange terminations and individual new business and HICS cases involving both policy issuance and policy terminations. Additionally, there was one (1) plan consisting of twenty-eight (28) enrollees that was issued off Exchange for commercial individuals.

Examiners reviewed a sample of twenty (20) Exchange initiated new business policies and found the Company timely issued the policy as directed by the Marketplace.

Review of insured requests issued through HICS for policy issuance and/or policy terminations were resolved timely with an average response time of five (5) days. There were no instances found of noncompliance.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard D.3. Acceptance of certain third-party payments. (2018 QHP Issuer Participation Standards C10d)**

**Test Methodology:**

- **QHP Participation Standard C10d:** Does the Issuer accept premium and cost-sharing payments for the QHPs from third-party entities? (Ryan White HIV/AIDS Program, Indian tribes, tribal organizations and local, state, or federal government program) [**45 CFR 156.1250**]

**Examiner Observations:** Although the Company has not received any third-party premium payments, there are procedures in place to accept these payments.

**Examiner Recommendations:** None

**Results:** Compliant

## E. ENROLLMENT AND RATING

The evaluation of standards for the business area related to the Company's enrollment and rating practices were based on responses to information requests, questions, interviews, presentations made to the examiner, and file sample reviews. The application process under Healthcare Reform no longer involves medical underwriting. This portion of the examination is designed to verify how the Company treats the public and whether that treatment is compliant with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. Samples were taken from the population of new business policies issued. In general, declinations and cancellations/terminations were reviewed under the Health Reform standards of guaranteed availability and guaranteed renewability. Federal regulations state that cancellations are a special type of termination of coverage that is retroactive to the inception date. Policy form and rate filings were not reviewed and were considered accepted as in compliance based on prior WVOIC filing and approval.

**Standard E.1: The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the regulated entity's rating plan.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §F, Standard 1 & **2018 QHP Issuer Participation Standards C2a)**

**Test Methodology:**

- Do the premium rates charged match the premium rates that were filed and approved? [W.Va. Code §33-16B-1]
- **QHP Participation Standard C2a**: Does the Company adhere to the premium payment rules established by the Exchange? [**45 CFR § 156.265(d) and 45 CFR § 155.240 and 45 CFR § 156.210(c)**]

**Examiner Observations:** Examiners reviewed new business premium rates for both open enrollment and special enrollment under plan year 2018. Sampled populations included both on Exchange and off Exchange enrollment. Examiners verified rates charged were the same as those

filed and approved by the WVOIC. Review of the payment process indicated compliance with the rules established by the Exchange.

**Examiner Recommendations:** None

**Results:** Compliant

**Table E.1** Results: Enrollment Sample

| Type | Population | Sample | Pass | Fail | Standard | Compliance |
|---|---|---|---|---|---|---|
| Open Enrollment/Special Enrollment (On Exchange) | 938 | 20 | 20 | 0 | 90% | 100% |
| Open Enrollment (Off Exchange) | 28 | 28 | 28 | 0 | 90% | 100% |
| TOTAL | 966 | 48 | 48 | 0 | 90% | 100% |

**Standard E.2. The QHP Issuer must reconcile enrollment information with the Exchange and acknowledge receipt of such information**. (2017 NAIC *Market Regulation Handbook*, Chapter 20, §F, Standard 2 and **2018 QHP Issuer Participation Standards C10e)**

**Test Methodology:**

- **QHP Participation Standard C10e:** Does the Issuer reconcile enrollment information with the Exchange on a monthly basis? [**45 CFR § 156.265(f) & (g)** and W.Va. Code § 33-6-7]

**Examiner Observations:** Examiners reviewed the Issuers reconciliation policy and procedures and found the Issuer to reconcile all Marketplace membership files received with the membership records in the enrollment system monthly.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard E.3: All forms, including policies, contracts, riders, amendments, endorsement forms and certificates are filed with the insurance department, if applicable.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §F, Standard 5)

**Test Methodology:**

- Did the Company use forms and endorsements that were filed and approved by the WVOIC? [W.Va. Code §33-6-8]

**Examiner Observations:** Examiners found during their review that the Company was only using forms and endorsements filed and approved by the WVOIC.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard E.4: A health carrier may not deny coverage or restrict coverage for qualified individuals, as defined in applicable statutes, rules and regulations, who participate in approved clinical trials.** (2017 NAIC *Market Regulation Handbook*, Chapter 20A, §A, Standard 1)

**Test Methodology:**

- Does the Company have established and implemented enrollment policies and procedures regarding the prohibition of denial and restriction of coverage for qualified individuals participating in approved clinical trials in accordance with statute and regulatory guidance established by HHS, DOL and the Treasury? (no statutory requirement)
- Does the Company deny participation by a qualified individual in an approved clinical trial? [W.Va. Code § 33-25F-2(c)(1) and (2) and 42 U.S.C. § 300gg-8]
- Do marketing materials provided to insureds and prospective purchasers by the Company provide complete and accurate information about coverage for individuals participating in approved clinical trials? [45 CFR § 156.225(b)]

**Examiner Observations:** The Company did not have any clinical trials during the examination period.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard E.5: A group health plan, or a health carrier offering group or individual health insurance coverage, that makes available dependent coverage of children shall make such coverage available for children until attainment of 26 years of age.** (2017 NAIC *Market Regulation Handbook*, Chapter 20A, §B, Standard 1)

**Test Methodology:**

- Does the Company have established and implemented enrollment policies and procedures related to extension of dependent coverage for individuals to age 26 in compliance with final regulations established by HHS, DOL and the Treasury? (no statutory requirement)
- Do the plan benefits vary based upon age, except for dependent children who are 26 years of age or older? [45 CFR 147.120(b)]
- Does the health carrier provide a dependent child whose coverage ended with at least a 30-day written notice of the opportunity to enroll in a health benefit plan? [45 CFR 147.120(f)]
- Were the policy forms filed and approved by the state for use in the QHP Marketplace? [W.Va. Code §33-6-8]

- Do marketing materials provided to insureds and prospective purchasers by the Company provide complete and accurate information about extension of coverage for dependents to age 26? [45 CFR § 156.225(b)]

**Examiner Observations:** Examiners did not observe coverage denials or cancellations for dependents up to age 26 during the exam. The Company's enrollment policies and procedures related to the extension of coverage for individuals to age 26 were reviewed and found to be in compliance. It is the policy of the Company to send a written notice thirty (30) days prior to the dependent child notifying them they will no longer be covered under the existing plan and of the opportunity to enroll in their own plan. Policy forms and marketing materials are reviewed by the WVOIC Rates and Forms Division prior to use.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard E.6: A health carrier offering individual market health insurance coverage shall issue any applicable health benefit plan to any eligible individual who: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) agrees to satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).** (2017 NAIC *Market Regulation Handbook*, Chapter 20A, §D, Standard 1) & **(2018 QHP Issuer Participation Standards C9 & C10)**

**Test Methodology:**

- Do the Company enrollment practices related to guaranteed availability provide adequate and appropriate processes to ensure the health carrier makes individual market health insurance coverage available on a guaranteed availability basis to eligible plan applicants in compliance with final regulations established by HHS, DOL and the Treasury? [W.Va. Code § 33-15-2b and 45 CFR § 147.104(a)]
- Do the Company complaint register/logs and complaint files identify complaints pertaining to restriction of guaranteed availability of coverage? [W.Va. Code § 33-15-2b and 45 CFR § 147.104(a)]
- Does the Company maintain proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible plan applicant who was not offered health insurance coverage on a guaranteed availability basis? [W.Va. Code R. § 114-15-4.2]
- Do the Company marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed availability of individual market health insurance coverage? [45 CFR § 156.225]
- **QHP Participation Standard C9:** Does the Company enroll qualified individuals only during the initial and annual open enrollment period; and make available special enrollment periods for eligible individuals? **[45 CFR § 155.420(d)(12)]**

- **QHP Participation Standard C10:** Does the Company comply with enrollment eligibility and qualification requirements? [**45 CFR § 156.265(b)**]

**Examiner Observations:** Examiners reviewed rates schedules, supplements and operating instructions, enrollment guidelines and marketing materials for both on and off the Exchange and determined them to be in compliance. The Company issued all Exchange policies as directed by the Marketplace.

**Examiner Recommendations:** None

**Results:** Compliant

**Table E.6** Results: Guaranteed Availability Sample

| Type | Population | Sample | Pass | Fail | Standard | Compliance |
|---|---|---|---|---|---|---|
| Open Enrollment/Special Enrollment (On Exchange) | 938 | 20 | 20 | 0 | 90% | 100% |
| Open Enrollment (Off Exchange) | 28 | 28 | 28 | 0 | 90% | 100% |
| TOTAL | 966 | 48 | 48 | 0 | 90% | 100% |

**Standard E.7: A health carrier offering individual market health insurance coverage shall renew or continue in force the coverage, at the option of the policyholder, subject to final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).** (2017 NAIC *Market Regulation Handbook*, Chapter 20A, §E, Standard 1)

**Test Methodology:**

- Do Company enrollment practices related to guaranteed renewability provide adequate and appropriate processes to ensure the health carrier renews, or continues in force, at the option of the policyholder, individual market health insurance coverage, in compliance with final regulations established by HHS, DOL and the Treasury? [W.Va. Code R. § 114-54-6 and 45 CFR § 147.106]
- Do Company enrollment practices ensure that nonrenewal or discontinuance of coverage of a health benefit plan is performed only as defined by applicable statutes and rules? [W.Va. Code R. § 114-54-6 and 45 CFR § 147.106]
- Do Company complaint register/logs and complaint files identify complaints pertaining to restriction of guaranteed renewability of coverage? [W.Va. Code R. § 114-54-6 and 45 CFR § 147.106]
- Does the Company maintain proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible plan applicant who was not offered health insurance coverage on a guaranteed availability basis? [W.Va. Code R. § 114-15-4.2]
- Do Company marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed renewability of individual market health insurance coverage? [45 CFR § 156.225]

**Examiner Observations:** Examiners reviewed a sample of on Exchange individual new business and verified members were enrolled as instructed by the Marketplace. Although a separate sample of renewals were not reviewed, examiners reviewed HICS cases and grievances and did not identify any that were related to denial of renewal coverage. All enrollment guidelines were determined to be compliant with regulations. All marketing materials provided complete and accurate information.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard E.8: A health carrier may not retrospectively rescind individual or group coverage (including family coverage in which the individual is included) unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact.** (2017 NAIC *Market Regulation Handbook*, Chapter 20A, §I, Standard 1)

**Test Methodology:**

- Does the Company rescind policies inappropriately? [45 CFR § 147.128]
- Does the Company take appropriate corrective action/adjustments regarding the reinstatement of coverage in a timely and accurate manner on the insured's policy when coverage has been rescinded inappropriately? [45 CFR § 147.128]
- Does the Company maintain proper documentation for all correspondence supporting corrective action provided to the insured, including website notifications? [W.Va. Code R. §114-15-4.2]

**Examiner Observations:** The Company had no rescinded policies during the examination period. There were no cancellations for fraud or misrepresentation.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard E.9: A health carrier offering group or individual health insurance coverage shall provide at least 30 days' advance written notice to each plan enrollee (in the individual market, primary subscriber) who would be affected before coverage may be rescinded.** (2017 NAIC *Market Regulation Handbook*, Chapter 20A, §I, Standard 2)

**Test Methodology:**

- Does the Company provide the required 30-day advance written notice to a plan enrollee, or in the individual market, a primary subscriber? [45 CFR § 147.128]

- Does the Company maintain proper documentation for all correspondence supporting corrective action provided to the insured, including website notifications? [W.Va. Code R. § 114-15-4.2]

**Examiner Observations:** The Company has a specific policy for rescissions. The Company had no rescinded policies during the examination period.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard E.10: The QHP Issuer must have premium payment processes that comply with regulations. (2018 QHP Issuer Participation Standards C10c)**

**Test Methodology:**

- **QHP Participation Standard C10c:** Does the QHP Issuer follow the premium payment rules established by the Exchange requiring payments to be accepted directly, electronically and from the Exchange and a process to determine accurate enrollment records? **[45 CFR 155.240 & 155.400e]**

**Examiner Observations:** The examiners reviewed DDWV's premium payment processes. The Company accepts payments directly, electronically and from the Exchange. Examiners reviewed open enrollments, special enrollment period (SEP) and changes in circumstances (CIC). No exceptions noted.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard E.11: Cancellation practices comply with policy provisions, HIPAA and state laws.** (2017 NAIC *Market Regulation Handbook*, Chapter 20, §A, Standard 1 and **2018 QHP Issuer Participation Standard C11a and C11b)**

**Test Methodology:**

- **QHP Participation Standard C11a:** Does the Company cancel policies for other than non-payment of premium? **[45 CFR § 155.430]**
- **QHP Participation Standard C11b:** Does the Company provide a three (3) month grace period if at least one (1) full month's premium was paid during the benefit year for QHP subsidized policies? **[45 CFR § 156.270(d)]**
- Did the Company comply with its filed and approved policy provisions with respect to cancellations, terminations and refunds? [W.Va. Code § 33-6-8]

**Examiner Observations:** It is the Company's policy to terminate coverage due to non-payment of premium, fraud or material misrepresentation, or if the enrollee no longer resides in the state of West Virginia. The Company had no individual off Exchange policy cancellations or terminations during the review period. Examiners reviewed on Exchange policy terminations for plan year 2017 through 2018. All policy terminations reviewed were for non-payment of premium and accompanied by an electronic 834 transactions to and from the Marketplace confirming the termination. Examiners verified the Company did not have any subsidized plans during the review period. It is the Company's policy to provide a grace period of thirty-one (31) days on premium payments. Examiners did not find any instances with respect to premium refunds.

**Examiner Recommendations:** None

**Results:** Compliant

**E. 11 Termination Sample**

| Type | Population | Sample | Pass | Fail | Standard | Compliance |
|---|---|---|---|---|---|---|
| Terminated Policies (On Exchange) | 4,274 | 25 | 25 | 0 | 90% | 100% |

## F. CLAIMS

The evaluation of standards related to the claims business area is based on Company responses to information requested by the examiner, discussions with Company staff, electronic testing of claim databases, and file sampling during the examination process. The claims portion of the examination is designed to provide a view of how the Company treats claimants, and whether that treatment is in compliance with applicable statutes and rules. As stated under the Methodology section, the claims samples were specifically selected to verify compliance with the ACA/QHP and other mandated benefits.

**Standard F.1: Claim files are handled in accordance with policy provisions, HIPAA and state law.** (2017 NAIC *Market Regulation Handbook*, Chapter 20, §G, Standard 1)

**Test Methodology:**

- Does the Company handle claims in accordance with policy provisions? [W.Va. Code § 33-45-2 and 45 CFR § 156.1010]
- Does the Company have procedures, training manual, and claim bulletins in place for the proper handling of claims in a fair and nondiscriminatory manner? [W.Va. Code §33-11-4(9)(c)]
- Did the Company pay benefits in accordance with its Evidence of Coverage?
- Did the Company apply cost sharing as indicated by the members plan?
- Were claims denied for appropriate reasons?
- Did the Company include proper language in its adverse determination notices?

**Examiner Observations:** The examiners reviewed sampled populations under plan year 2017 of both paid and denied claims for adherence to policy provisions as indicated in the table below. Company claims handling procedures were reviewed to ensure adherence to policy contract provisions. Examiners found no instances of noncompliance. Examiner confirmed claims were processed in accordance with policy benefits outlined in members Evidence of Coverage. Examiners review of sampled denial claims found no claims denied inappropriately. Examiners reviewed EOB's associated with claim denials and confirmed they contain procedures for the review of the claim denial.

**Examiner Recommendations:** None

**Results:** Compliant

**Table F.1** Results: Claims Sample

| Type | Total Population | Paid Sample | Pass | Fail | Standard | Compliance |
|---|---|---|---|---|---|---|
| Paid Claims | 205,646 | 109 | 109 | 0 | 93% | 100% |
| Denied Claims | 28,195 | 50 | 50 | 0 | 93% | 100 |
| TOTAL | 233,841 | 159 | 159 | 0 | 93% | 100% |

**Standard F.2: Claims are resolved in a timely manner.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §G, Standard 3)

**Test Methodology:**

- Does the Company resolve claims in accordance with state requirements? [W.Va. Code §33-45-2(a)(1) & (a)(3)]

**Examiner Observations:** W. Va. Code § 33-45-2 provides the time standards for "clean claims"; for claims submitted electronically the requirement is thirty (30) days to either pay or deny the claim; for claims submitted by paper the standard is forty (40) days. Although W. Va. has no specific time requirement with respect to non-contracted (out of network) providers, untimely processing of these claims may subject claimants to adverse actions from providers. The Company appears to either pay or deny a claim well within required timeframes regardless of submission type.

**Examiner Recommendations:** None

**Results:** Compliant

**Table F.2** Results: Claims Sample

| Type | Total Population | Paid Sample | Pass | Fail | Standard | Compliance |
|---|---|---|---|---|---|---|
| Paid Claims | 205,646 | 109 | 109 | 0 | 93% | 100% |
| Denied Claims | 28,195 | 50 | 50 | 0 | 93% | 100% |

| Type | Total Population | Paid Sample | Pass | Fail | Standard | Compliance |
|---|---|---|---|---|---|---|
| TOTAL | 233,841 | 159 | 159 | 0 | 93% | 100% |

**Standard F.3: Claim files are adequately documented.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §G, Standard 5)

**Test Methodology:**

- Does the Company adequately document all claim files? [W.Va. Code R. § 114-15-4]
- Does the Company maintain claim file documentation in accordance with state retention requirements? [W. Va. Code R. § 114-15-4]

**Examiner Observations:** Examiners reviewed claims files and determined that all are adequately documented.

**Examiner Recommendations:** None

**Results:** Compliant

**Table F.3** Results: Claims Sample

| Type | Total Population | Paid Sample | Pass | Fail | Standard | Compliance |
|---|---|---|---|---|---|---|
| Paid Claims | 205,646 | 109 | 109 | 0 | 93% | 100% |
| Denied Claims | 28,195 | 50 | 50 | 0 | 93% | 100% |
| TOTAL | 233,841 | 159 | 159 | 0 | 93% | 100% |

**Standard F.4: A health carrier may not deny coverage or restrict coverage for qualified individuals, as defined in applicable statutes, rules and regulations, who participate in approved clinical trials.** (2017 NAIC *Market Regulation Handbook*, Chapter 20A, §A, Standard 1)

**Test Methodology:**

- Does the Company deny, limit or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in a trial? [W.Va. Code §§ 33-25F-2(c)(1) and (2) and 42 U.S.C. § 300gg-8)]
- Does the Company maintain proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual for whom coverage for participation in an approved clinical trial was inappropriately restricted or denied? [W.Va. Code R. § 114-15-4.2]

**Examiner Observations:** The Company has policies and procedures for clinical trials which are compliant with code sections above. There were no benefit requests for covered services in conjunction with clinical trials during the examination period.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard F.5: A health carrier shall not establish any lifetime or annual limit on the dollar amount of essential health benefits (EHB)s for any individual, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).** (2017 NAIC *Market Regulation Handbook*, Chapter 20A, §F, Standard 1)
**Test Methodology:**

- Does the Company apply lifetime/annual limits on the dollar amount of essential health benefits for any individual, in violation of final regulations established by HHS, the DOL and the Treasury? [45 CFR § 147.126]

**Examiner Observations:** Review of the policy plans determined that no lifetime or annual limits were applied in compliance with 45 CFR § 147.126. There were no instances of lifetime/annual limits found within the claims sample.

**Examiner Recommendations:** None

**Results:** Compliant

**Table F.5** Results: Claims Sample

| Type | Total Population | Paid Sample | Pass | Fail | Standard | Compliance |
|---|---|---|---|---|---|---|
| Paid Claims | 205,646 | 109 | 109 | 0 | 93% | 100% |
| Denied Claims | 28,195 | 50 | 50 | 0 | 93% | 100% |
| TOTAL | 233,841 | 159 | 159 | 0 | 93% | 100% |

**Standard F.6: A health carrier shall not impose cost sharing requirements upon preventive services, as defined in, and in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).** (2017 NAIC *Market Regulation Handbook*, Chapter 20A, §H, Standard 1)

**Test Methodology:**

- Does the Company take appropriate corrective action/adjustments on the insured's policy deductibles, copayments, coinsurance and other cost-sharing mechanisms in a timely and

accurate manner when improper assessment of cost-sharing upon insureds occurs? [45 CFR § 147.130]

- Does the Company maintain proper documentation for all correspondence supporting corrective action provided to the insured, including website notifications? [W.Va. Code R. § 114-15-4.2]
- Do the Company's enrollment materials, marketing and sales materials, and other information disseminated to applicants/proposed insureds, insureds and claimants provide complete and accurate information about the restriction of cost-sharing methods the health carrier may impose on the insured for preventive items and services described in the final regulations established by HHS, the DOL and the Treasury? [W.Va. Code § 33-11-4 and 45 CFR § 155.225]
- Does the Company properly apply deductibles, co-payments, coinsurance and other methods of cost-sharing on preventive items and services, in accordance with final regulations established by HHS, the DOL and the Treasury? [45 CFR § 147.130]

**Examiner Observations:** Examiners review of benefit plan documents and claims determined that the company does not impose cost sharing requirements upon preventive services, as defined in, and in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

**Examiner Recommendations:** None

**Results:** Compliant

**Table F.6** Results: Claims Sample

| Type | Total Population | Paid Sample | Pass | Fail | Standard | Compliance |
|---|---|---|---|---|---|---|
| Paid Claims | 205,646 | 109 | 109 | 0 | 93% | 100% |
| Denied Claims | 28,195 | 50 | 50 | 0 | 93% | 100% |
| TOTAL | 233,841 | 159 | 159 | 0 | 93% | 100% |

## G. COMPLAINTS/GRIEVANCES/APPEALS/HICS

Evaluations of the standards in the Company's complaint handling business area are based on Company responses to various information requests and the review of complaint files at the Company. Complaints reviewed included "direct" consumer complaints and complaints received from the Office of the Insurance Commissioner. There are competing regulatory and statutory requirements for Health Entities regarding complaints and grievances. The definition of a complaint is, "...any written communication primarily expressing a grievance." There are no specific regulatory or statutory timeframes regarding responses to complaints received at the Offices of the Insurance Commissioner; however, the WVOIC Consumer Services Division has adopted a fifteen (15) working day timeframe for responses to its office.

W.Va. Code §33-11-4(10) requires the Company to "...maintain a complete record of all complaints which it has received since the date of its last examination." The statute also requires that the Company maintain records to indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint.

As DDWV offers plans through the Federally Facilitated Marketplace, it is also required to respond to cases initiated through the Health Insurance Casework System (HICS) as outlined in 45 CFR § 156.1010(b). HICS is used by the Marketplace to communicate directives related to certain coverage changes covered in Standard G8; however, cases may not necessarily be complaints.

DDWV is domiciled and licensed in West Virgina as a dental service corportation and provides only limited scope dental benefits on a stand alone basis. The regulatory requirements of West Virginia's Health Plan Issuer Internal Grievance Procedures specifically apply to health benefit plans offered by issuers as defined under W.Va. Code R. § 114-96-2.18 and therefore excludes limited scope dental benefits and issuers. DDWV maintains an internal grievance/appeal procedure which can be accessed on line or by contacting the company directly. An enrollee grievance may be submitted via telephone, written correspondence, website, fax or email. A written acknowledgement from the Company is sent to the enrollee within five (5) calendar days following receipt of the appeal or grievance. A written decision is sent to the enrollee within thirty (30) days [or 60 days under group health plans subject to the Employee Retirement Income Secuirty Act of 1974 (ERISA)]. If more information or time is needed by the Company for review, the enrollee will be be informed of the pending status of their grievance.

**Standard G.1: All complaints are recorded in the required format on the regulated entity's complaint register.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §B, Standard 1)

**Test Methodology:**

- Does the Company record and maintain a complaint register with all required information? [W.Va. Code R. § 114-15-4.6]

**Examiner Observations:** The Company records and maintains a complaint register and a log of all WVOIC complaints.

**Examiner Recommendations:** None

**Results:** Compliant

**Table G.1** Results: WVOIC Complaints

| Type | Population | Sample | Pass | Fail | Standard | Compliance |
|---|---|---|---|---|---|---|
| WVOIC Complaints | 20 | 20 | 20 | 0 | 90% | 100% |

**Standard G.2: The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §B, Standard 3)

**Test Methodology:**

- Does the Company respond fully to the issues raised in all complaints? [W. Va. Code R. § 114-53]
- Does the Company adequately document all complaint files? [W. Va. Code R. §§ 114-53 & 96 & 15-4 & 45 CFR 147.136 (b)(3)(ii)(H)]

**Examiner Observations:** Examiners reviewed all WVOIC complaints and grievances involving adverse determinations and found all were responded to fully. Files were adequately documented.

**Examiner Recommendations:** None

**Results:** Compliant

**Table G.2** Results: WVOIC Complaints

| Type | Population | Sample | Pass | Fail | Standard | Compliance |
|---|---|---|---|---|---|---|
| WVOIC Complaints | 20 | 20 | 20 | 0 | 90% | 100% |

**Standard G.3: The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations.** (2017 NAIC *Market Regulation Handbook*, Chapter 16, §B, Standard 4)

**Test Methodology:**

- Does the Company respond timely, within 15 working days, to the issues raised in all complaints received by the WVOIC? [There are no specific regulatory or statutory timeframes regarding responses to complaints received at the Offices of the Insurance Commissioner; however, the WVOIC Consumer Services Division has adopted a fifteen (15) working day timeframe for responses to its office. ]

**Examiner Observations:** The review of WVOIC complaints determined that the Company timely responded to the WVOIC Consumer Services Division.

**Examiner Recommendations:** None

**Results:** Compliant

**Table G.3** Results: WVOIC Complaint Timely Response Sample

| Type | Population | Sample | Pass | Fail | Standard | Compliance |
|---|---|---|---|---|---|---|
| WVOIC Complaints | 20 | 20 | 20 | 0 | 90% | 95% |

**Standard G.4: A health carrier offering individual health insurance coverage shall maintain records of all claims and notices associated with the internal claims and appeals process for the length of time specified in the final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).** (2017 NAIC *Market Regulation Handbook*, Chapter 20A, §C, Standard 1)

**Test Methodology:**

- Does the Company maintain and make available grievance records for at least six years for all grievances? [45 CFR § 147.136(b)(3)(H)]
- Does the Company maintain all QHP documents and records for at least ten (10) years? [45 CFR § 156.705(c)]

**Examiner Observations:** The Company has written policies and procedures which are compliant with the above referenced regulations stating that all grievance records are retained for at least ten (10) years.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard G.5: A health carrier has implemented grievance procedures, disclosed the procedures to covered persons, in compliance with applicable state statutes, rules and regulations, and files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance and comply with grievance procedures requirements, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).** (2017 NAIC *Market Regulation Handbook*, Chapter 20, §H, Standard 3) (2017 NAIC *Market Regulation Handbook*, Chapter 20A, §C, Standard 2)

**Test Methodology:**

- Does the Company have procedures for and conduct first level reviews of grievances involving an adverse determination to include a statement of a covered person's right to contact the insurance commissioner's office or ombudsman's office for assistance at any time, and include the telephone number and address of the insurance commissioner or ombudsman's office in compliance with applicable statutes, rules and regulations? [42 U.S.C. § 300gg-19 and 45 CFR § 147.136]
- Did the examiners observe any instances of member communications that could be construed as a grievance that were not treated as such?
- Does the Company maintain a grievance register consisting of written records to document all first level and expedited grievances received during a calendar year (the register) in the format prescribed by law? [W.Va. Code §33-11-4(10)]

**Examiners Observation:** The company has grievance procedures for handling grievances, which are communicated to the members online, the EOB's and EOC's. Examiners observed no additional instances of member communications that could have been construed as a grievance in their review of enrollment and claims files.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard G.6: The health carrier shall conduct first-level reviews of grievances involving an adverse determination in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).** (2017 NAIC *Market Regulation Handbook*, Chapter 20A, §C, Standard 3)

**Test Methodology:**

- Does the Company ensure that the first level review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the review decision? [45 CFR § 147.136(b)(2)(ii)(D)]
- Does the Company provide the notice in a culturally and linguistically appropriate manner in accordance with federal regulations? [45 CFR § 147.136(b)(2)(ii)(E)]
- Does the Company provide the notice as required in case of disenrollment or rescission, as included in the definition of adverse determination? [45 CFR § 147.136(b)(3)(ii)(A)]

**Examiner Observations:** The examiners reviewed the Company's claims appeal procedures of adverse determinations and verified reviews are conducted by a person who is neither the individual who made the claims denial subject to the review, nor the subordinate of such individual.

The examiners reviewed twenty-five (25) off Exchange member appeals from a sampled population of forty-nine (49) for 2017 and 2018. Examiners also reviewed the total population of five (5) for the on Exchange member appeals. Although no violations were noted, upon review of the Companys online grievance procedures forms, examiners noted the forms directed and referred members to Delta Dental of California, not West Virginia. The Company agreed with the examiners findings and initiated corrective action prior to the examination conclusion.

The Company did not have any cases of disenrollment or rescissions during the examination period.

**Examiner Recommendations:** None

**Results:** Compliant

Table G.6 Results: Grievance/Appeal Sample

| Type | Population | Sample | Pass | Fail | Standard | Compliance |
|---|---|---|---|---|---|---|
| Grievance/Appeals Adverse Determination PPO (Off Exchange) | 49 | 25 | 25 | 0 | 90% | 100% |
| Grievances/Appeals (On Exchange) | 5 | 5 | 5 | 0 | 90% | 100% |
| TOTAL | 54 | 30 | 30 | 0 | 90% | 100% |

**Standard G.7: The health carrier shall conduct expedited reviews of urgent care requests of grievances involving an adverse determination in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of labor (DOL) and the U.S. Department of the Treasury (Treasury).**
(2017 NAIC *Market Regulation Handbook*, Chapter 20A, §C, Standard 4)

**Test Methodology:**

- Does the Company have established and implemented written policies and procedures regarding receiving and resolving expedited review of urgent care requests of grievances involving an adverse determination in accordance with final regulations established by HHS, the DOL and the Treasury? [45 CFR § 147.136(b)(2)(ii)(A)]
- Does the Company provide the notice in a culturally and linguistically appropriate manner in accordance with federal regulations? 45 CFR § 147.136(b)(2)(ii)(E)]

**Examiner Observations:** Examiners reviewed the Company's internal policy and procedures for circumstances involving an expedited, urgent or emergency grievance. An emergency grievance is to be acknowledged and resolved within three (3) calendar days if the enrollee is posed with imminent and serious threat to their health.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard G.8: Handling of Health Insurance Casework System (HICS) (2018 QHP Issuer Participation Standards C12)**

**Test Methodology:**

- **QHP Participation Standard C12 a.i.1:** Does the Company have policy regarding the processing of HIC's casework including monitoring daily for new cases? **[45 CFR § 156.1010(b)]**
- **QHP Participation Standard C12 a.i.2.a.b:** Does the Company resolve HICS standard cases within 15 calendar days and urgent complaints within 72 hours? **[45 CFR § 156.1010(d)]**
- **QHP Participation Standard C12:** Does the Company meet timeliness criteria for both urgent and standard cases for notification of resolution to the member? Is the resolution of

the complaint reasonable and was the insured appropriately notified? **[45 CFR § 156.1010(f)]**

- **QHP Participation Standard C12:** Does the Company upload the resolution summary into the FFM casework tracking system within seven (7) business days after resolution? **[45 CFR § 156.1010(g)(2)]**

**Examiner Observations:** Examiners reviewed the Company policy for processing HICS related cases and verified they are processed on a priority basis and monitored daily for new cases which are tracked and resolved within ten (10) working days. The examiners found no instances of urgent complaints.

Examiners chose to review for the 2018 protocol period only. The population for the period of 01/01/2018 to 03/31/2018 was sixty (60). There were no instances of DDWV failing to comply with requests through HICS as received. All responses to resolution were replied to on average within five (5) days through 834 transactions. After review of twenty-five (25), as there were no issues found, it was determined the review would end.

**Examiner Recommendations:** None

**Results:** Compliant

**Table G.8** Results: Health Insurance Casework System Complaints (HICS)

| Type | Population | Sample | Pass | Fail | Standard | Compliance |
|---|---|---|---|---|---|---|
| HICS Cases | 60 | 25 | 25 | 0 | 90% | 100% |

## H. NETWORK ADEQUACY

The evaluation of the business area related to the Company's network adequacy is based on Company responses to information requested by the examiner, discussions with Company staff. This portion of the examination is designed to test whether the Company has sufficient providers to cover all the medical and mental health needs of each of the members.

**Standard H.1: The company demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers to ensure that all services to enrollees will be accessible without unreasonable delay.** (2017 NAIC *Market Regulation Handbook*, Chapter 20, §I, Standard 1 and **2018 QHP Issuer Participation Standards C15**)

**Test Methodology:**

- Has the Company established and maintained adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residences of enrollees? [W. Va. Code R. § 114-53-6, Informational Letter 112 and **45 CFR § 156.230**]

- **QHP Participation Standard C15:** Does the Company monitor, on an ongoing basis, its providers, provider groups, and intermediaries with which it contracts, to ensure the ability, clinical capacity, financial capability and legal authority, including applicable licensure requirements, to furnish all contracted benefits to enrollees? [**45 CFR § 156.340**]

**Examiner Observations:** Prior to licensing approval, the WVOIC Rates and Forms division has a practice to check the Company's network adequacy. The examiners did not duplicate this review, but rather performed tests as indicated in this section which address maintenance of network and communication to Company members.

**Examiner Recommendations:** None

**Results:** Compliant

**Standard H. 2: The company provides at enrollment a directory of providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory and files the directory with the insurance commissioner.** (2017 NAIC *Market Regulation Handbook*, Chapter 20, §I, Standard 7 and **QHP Issuer Participation Standards C6**)

**Test Methodology:**

- **QHP Participation Standard C6:** Does the Company provide directory updates to enrollees and to the insurance commissioner at the frequency required by federal law? [**45 CFR § 156.230**]

**Examiner Observations:** Examiner's randomly contacted by telephone five (5) providers using the information on the Company's online directory. The examiner observed one (1) provider telephone number only reached a recording to leave a message and provided no additional information. One (1) other provider was listed on the online directory as accepting new patients; however, during the call the examiner was advised the provider was not taking new DDWV patients. Company corrective action prior to examination conclusion included DDWV advising that in the first instance the provider was still using the same telephone number on claim submissions but would contact the provider and update the directory if warranted. The provider no longer accepting new patients was surpressed from the provider directory. The Company responded that the providers have the capability and are advised to update their information online. Updates are done in order of receipt, but no later than thirty (30) days.

**Examiner Recommendations:** None

**Results:** Compliant

## SUMMARY OF RECOMMENDATIONS

A formal list of examiner recommendations has been deemed unnecessary as there were no standards of non-compliance found during the examination. Furthermore, the Company completed corrective action on all items required prior to examination completion.

## EXAMINER'S SIGNATURE AND ACKNOWLEDGEMENT

The examiner would like to acknowledge the cooperation and assistance extended by the Company during the course of the examination, in particular Michelle Shutt, Regulatory Analyst and Roxanna A. Young, Esq., Manager, Regulatory.

In addition to the undersigned, Mark Hooker, CIE, CPCU, CLMI, PIR, AMCM, CWCP, CCP, AIRC, FAHM, John Stike, CIE, CPCU, MCM, CWCP, CIPA, AU, APA, AFI, Barbara A. Hudson, AIE, MCM, CWCP, PAHM , and Letha Tate, MCM all with the West Virginia Offices of the Insurance Commissioner also participated in this examination.

Desiree D. Mauller CIE,CWCP, MCM
Examiner-in-Charge

EXAMINER'S AFFIDAVIT

**State of West Virginia**

**Kanawha County**

**EXAMINER'S AFFIDAVIT AS TO STANDARDS AND PROCEDURES USED IN AN EXAMINATION**

I, Desiree D. Mauller, being duly sworn, states as follows:

1. I have the authority to represent West Virginia in the examination of Delta Dental of West Virginia.

2. I have reviewed the examination work papers and examination report, and the examination of Delta Dental of West Virginia was performed in a manner consistent with the standards and procedures required by West Virginia.

The affiant says nothing further.

Desiree D. Mauller CIE,CWCP, MCM
Examiner-in-Charge

Subscribed and sworn before me by Desiree D. Mauller this 2nd day of November 2018.

Notary Public Georgia Lea Cisco

My commission expires: 10-11-2019

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
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My Commission Expires October 11, 2019